

Canakinumab (Ilaris)

Provider Order Form rev. 9/28/2021



PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

THERAPY ADMINISTRATION

Canakinumab (Ilaris)

For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis.

4mg/kg (with a max of 300mg) for patients with a body weight greater than or equal to 7.5kg subcutaneous every 4 weeks

For Cryopyrin-Associated Periodic Syndromes (CAPS)

- 150mg for patients with body weight greater than 40kg subcutaneous every 8 weeks
- 2mg/kg for patients with body weight greater than or equal to 15kg and less than or equal to 40kg subcutaneous every 8 wks

For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever

Body weight less than or equal to 40kg

- 2mg/kg subcutaneous every 4 weeks
- 4mg/kg subcutaneous every 4 weeks - consider if clinical response not adequate.

Body weight greater than 40kg

- 150mg subcutaneous every 4 weeks
- 300mg subcutaneous every 4 weeks - consider if clinical response not adequate.

Refills: Zero / for 12 months / _____ (if not indicated order will expire one year from date signed)

NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)
- TB status & date (list results here & attach clinicals)

OBSERVATION (PLEASE SELECT BELOW)

- Patient is required to stay for 30 minutes observation period
- Patient is NOT required to stay for observation time
- Other: _____

SPECIAL INSTRUCTIONS

Prior to initiating immunomodulatory therapies, including ILARIS, patients should be evaluated for active and latent tuberculosis infection.

Provider Name (Print) _____ Provider Signature _____ Date _____

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> TAMPA: 844-946-0849 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> WEST FLORIDA: 844-946-0849 | <input type="checkbox"/> EAST TN: 888-615-1445 |